Soliris Infusion Order

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:

❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP
❒ H & P Relevant to Diagnosis ❒ Current Medications
❒ NMOSD: Positive AChR Antibody Test ❒ gMG: Positive AQP4 Antibody Test
❒ Meningococcal Vaccination: Must have 2 vaccine type at least 2 wks prior
❒ MeniACWY (2 Doses) Menveo or Menactra Date of 1st/2nd dose: _____
AND ❒ MenB-4C (2 Doses) Bexsero Date of 1st/2nd dose: _____
OR ❒ MenB-FHbp (3 Doses) Trumenba Date of 1st/2nd/3rd dose: _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○lbs / ○kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

SOLIRIS (ECULIZUMAB) IV DOSAGE:

Date of Last Treatment, If Continuation:

❒ Dosage for aHUS, Myastheia Gravis, and NMOSD
900 mg once weekly for 4 weeks, 1200 mg on week 5. then 1200 mg every 2 weeks therafter

❒ Dosage for PNH
600 mg once weekly for 4 weeks, 900 mg on week 5. then 900 mg every 2 weeks therafter

❒ Other

_____ mg every _____

***Must be enrolled and authorized in the Soliris-REMS Program.**